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ABSTRACT

The paper focuses on training efforts resulting from a grant awarded to the Colorado Department of Health in 1976 by the Western Area Alcohol Education and Training Program. A tape on the physiological aspects of alcoholism developed during the grant year was used in conjunction with the paper, and both were very well received. The grant was a cooperative effort between Fort Logan's Applied Training for Alcoholism Specialists (ATAS) Program and the Alcohol and Drug Abuse Division. Training goals for the project, January 1976 through January 1977, were threefold: (1) To provide one month of training at the ATAS for alcoholism program directors and supervisors using the "Training the Trainer" model; (2) To provide training and education in the basic skills of alcoholism identification for 60 new staff members of non-hospital detoxification centers at the ATAS program at Fort Logan Mental Health Center; (3) To provide on-site training programs, workshops and consultation for persons working in the alcohol field who did not have access to more formal programs. The program staff was well satisfied with the results they achieved, which are briefly described in the paper. (Author)

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Development of Alcoholism Programming in Colorado and Subsequent Training Efforts

As an introduction to my discussion of our current training program, let me first share very briefly the history of alcoholism program development in Colorado from July 1974 to December 1976.

In July 1974 alcoholism treatment services in Colorado consisted of two state hospital programs, four private programs, three NIAAA programs, and a few poorly funded halfway houses. The Colorado version of the Uniform Intoxication Act, "HB 1279" which decriminalizes public intoxication and mandates treatment and includes a commitment process had been passed and became effective July 1, 1974. The first state allocation of funding for treatment of alcoholism outside the walls of a state hospital had been made, $550,000. In 1974 the alcoholism section staff consisted of a chief, assistant chief, and secretary. A plan for program development to develop the services needed to implement the uniform act had been written the previous year by the section chief, who was hired as a consultant at that time, and was then hired to implement the plan. The Long Bill request for alcoholism programs for fiscal year 1977 was $2,409,176, but cut later by $500,000.

The first order of business was program development within the constraints of funding in the Long Appropriations bill. There were many meetings with county commissioners, citizen groups, developing advisory boards, etc. to provide information about alcoholism, potential of treatment, nature of treatment programs, costs to local communities, and other questions pertinent to a region. There was a consistent effort to encourage local planning and decision making regarding programs to be instituted. Alcohol section staff would be responsible for educating and providing technical assistance in program planning and development as well as initiating a divisional policy that called for sign-off by local Council of Government and Comprehensive Health Planning before programs were funded. Staff time ranged from seven to ten meetings before an organization was ready to develop a program. There are now 21 detoxification programs, 27 inpatient rehabilitation programs (halfway houses), and 34 outpatient programs funded at least partially by public funds.

In 1975 licensing standards were developed as mandated by HB 1279. The first year there were 17 licensed programs, the second year 23, and currently 77 programs are either licensed or in the process of being licensed. A third staff member was hired to handle the vastly increased workload in this area, as well as to assist with increasing administrative responsibilities. In June 1976, the licensing standards were rewritten to assure quality programs by addressing issues such as numbers and qualifications of staff, programmatic aspects and record keeping as well as physical facilities. In July 1976 public hearings were held and the standards were adopted. A cooperative agreement was developed with the Environmental Health Division of the Colorado Department of Health to facilitate inspection of physical facilities.

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Western Area Alcohol Education and Training Program
Grant Number 750417
January 1976 - January 1977

With the rapid program development, it became apparent that there was an urgent need for training of staff of alcoholism programs. Alcoholism staff knew they could not do both administration and training without additional help. Therefore, a grant was written and awarded by the Western Area Alcohol Education and Training Program to provide field training and to coordinate with the existing Fort Logan Mental Health Center training program (ATAS) by providing stipends for staff attending that program. The grant also provided field supervision staff, and four directors' workshops to enable training to continue at the program level. (training the directors to be trainers)

Training goals for January 1976 through January 1977 were three fold:

1. To provide one month of training at ATAS for program directors and supervisors using the "Training the Trainer Model".

2. To provide training and education in the basic knowledge and skills of alcoholism identification for 60 new staff members of non-hospital detoxification centers at the ATAS program at Fort Logan Mental Health Center.

3. To provide on-site training programs, workshops, and consultation for persons working in the alcohol field who do not have access to more formal programs

Table I

Objectives	Projected Figures For Jan 1976 - Jan 1977	Actual Figures For One Year
1. Total number of persons trained (some have received more than one training session)	830	2,513
2. Number of alcohol programs receiving training (some of these programs have received from three to ten training sessions)	44	95
3. Number of program directors and/or supervisors	15	16
4. Number of alcohol program personnel to ATAS	60	72
5. Number of community agencies not directly involved with alcoholism treatment	24	42
6. Number of training hours		19,501
7. Number of miles traveled by trainers In addition, there were many trips by plane.		29,118

As you can see in Table I, we have exceeded our expectations in every area!

Objectives for goal number one, training directors and supervisors, were met in the following manner:

The training experience for program directors and supervisors was divided into four, one week segments spread over eight months. The first week focused on system monitoring and management and staff monitoring and supervision.

The second week session focused on group management models, management by objectives, problem oriented record keeping, and individual management styles.

The third week focused on training the directors and supervisors to become trainers. Presentations were done by trainees in social systems, personnel analysis, family support systems, conflictual values, review of medical screening, crisis intervention, and early motivational counseling as well as behavioral management.

The fourth and final week consultants and staff presented management styles follow-up, grant writing, mobilizing the community, use of media in writing and presenting radio and television spots, and use of volunteers. All participants in these workshops were enthusiastic, and felt that they had either learned new skills or enhanced those skills they came with. An offshoot of this endeavor was that all of the directors sent their staff for training in the subsequent six months that the grant was in effect. They (the directors) are still asking for a follow-up workshop. The team building that occurred was probably the most effective aspect of this series.

Objectives for goal number two were met by having detox center staff participate in the one week on-site training at Fort Logan. The ATAS program covers the five basic core processes:

1. Skills and techniques of diagnostic and therapeutic interviewing.
2. Diagnoses and assessment of alcohol problems
3. Group process for diagnosing.
4. Treatment approaches and strategies and their theoretical foundation.
5. Medical and physiological aspects of alcoholism.
6. Community resource utilization.
7. Values orientation.

These modules are all covered in the training manual and is available to you upon request.

In order to evaluate the training, pre and post testing was done, but the results are not yet tabulated.

Objectives for goal number three were met by having our two field trainers go into a particular community upon request and work with program staff to develop a training plan.

The on-site field training was originally intended to train non-hospital detox staff, and possibly inpatient rehabilitation staff. However, as the field trainers became known and trusted in the community, the needs of the programs and the needs of the community began to emerge. For instance, we found that medical staff at hospitals and nursing homes needed training in evaluating the inebriated person and behavioral management. Persons in police work, sheriff departments, and community action centers needed training in management, crisis intervention, and referral skills.

On-site training in the following areas was provided:

1. Medical management of the inebriate including basic triage skills.
2. Physiological aspects of alcoholism.
3. Medical crisis, management, and referral of.
4. Crisis intervention and early motivational counseling.
5. Family unit therapy.
6. Basic group process and diagnosis.
7. Treating drinking behavior.

Field supervision and follow-up was also provided for ATAS trainees by the two field trainers.

Much use was made of media techniques. We have a full time media technician at ATAS, and have purchased portable video equipment for use in the field. There is no more effective way to provide feedback in basic interviewing techniques and counseling techniques than to visually observe and critique your performance. We use video heavily in the directors' workshops to critique training, supervising, and group techniques.

Let me focus on the field training more specifically. With the use of non-degree professionals, including many recovering alcoholics becoming more and more the norm we found that a "show and tell" type of approach was essential. One of our field trainers was a registered nurse with experience in the emergency room of Denver's county hospital as a member of the alcoholism evaluation team. The other trainer had extensive experience in crisis intervention, family counseling, group skills, systems intervention, and behavioral management in various psychiatric settings.

These two people traveled throughout Colorado doing "on-the-spot" needs assessment and evaluating training potential as well as doing the training. Whenever possible, they tried to train an individual in the system to become an in-house trainer, but as many of our rural areas have very small programs and are under funded, this was not always possible. Many of the programs are very unsophisticated, and the trainers would show the staff how to carry out a procedure; e. g., vital signs and then watch the staff practice. Often they would work a shift with staff and help admit an intoxicated client, work with the family, do a social history, and establish a problem oriented record. When a workshop was presented followed by a practical demonstration and then followed by a one-to-one rehash, the most insecure staff person began to feel confident and willing to try out his own skills. We also used portable video equipment to tape counseling skills; for example, attending behavior, use of minimal encouragers, reflection of feeling, etc.

In critiquing the trainee, great care must be given to emphasize or build on the strengths while dealing with poor techniques.

On-site training had many advantages; the availability of clients, the security of being on one's own turf, and the support of a peer group. A small program cannot afford to send staff away for one week or one month. However, there were may distractions as well. Clients and telephones make a constant demand and are disruptive to the trainee. There is always an available "out" when the situation becomes threatening.

The Fort Logan training site is an old duplex remodeled to meet the needs of the training program. It is warm and inviting with vibrant colored drapes and psychodrama lights to offset the sterility of blackboard and newsprint. Overall, we found the setting at Fort Logan to be more conducive to establish group cohesion and providing a better atmosphere in which learning could take place.

The Fort Logan Applied Training program had a mix of trainees that proved very valuable. In addition to non-hospital detox staff, and staff from NIAAA programs, some of whom were non-degree professionals, others were master degree psychologists and nurses, etc. We found that they had much to offer each other. The "professional" (and I say that in quotes because many of our non-degree people are among the most professional people in our field); the "professional degreed person had much to offer in the quest for" what is the difference between 12 step work and professional counseling?" The recovering alcoholic had much to share in his/her life experience.

Some trainees came with a willingness to learn, but many were sent with a resentment. Social workers, psychologists, ministers, etc. came to the training program feeling that they had the basic counseling skills, but found there was much more to learn about counseling the alcoholic. Recovering alcoholics came feeling that they knew all there was to know about alcoholism, but found that there was much to learn about putting that knowledge in a professional framework, and about the difference between a therapist, therapeutic interaction, and a social role.

We are talking about and much stress was put on attitudes. Looking at one's value system, examining the historical role of drunkenness, and changing one' own attitude were stressed throughout all aspects of the training. Role modeling was consciously employed, and role playing was practiced. I strongly feel that the attitude we bring to a session as clinicians, as administrators, or as trainers, is far more relevant than the most up-to-date techniques. I feel very strongly that such training must be implemented if the program development is to be successful. New programs need staff development to parallel organizational development. Often new programs need community development long before they begin to develop even the skeleton of a program. Most certainly they need the support of the local COG, community mental health centers, and county commissioners. Community development is where field training begins. I have come full circle.

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Abstract

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- To provide on-site training programs, workshops and consultation for persons working in the alcohol field who did not have access to more formal programs.

The audience at FuturAction was particularly interested in the field training concept described in the paper and the use of video feedback for training.